Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH FORT WORTH
3255 W PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-13-1176-01

MFDR Date Received
January 14, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Outpatient Hospital Rule 134.03, HCPC's are payable at 200% of the correct fee schedule allowable."

Amount in Dispute: $235.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No additional payment is due."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2012	Outpatient Hospital Services	$235.00	$1.64

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 767 – REIMBURSED PER O/P FG AT 200% SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDING CERTIFICATION) NOT REQUESTED PER RULE 134.403(G)

- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
- CAC – W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC – 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 71010 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.84. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.90. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of $25.57. The non-labor related portion is 40% of the APC rate or $17.94. The sum of the labor and non-labor related amounts is $43.51. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $43.51. This amount multiplied by 200% yields a MAR of $87.02.
   - Procedure code 72125 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8005. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
   - Procedure code 70450 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8005. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included

in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.

- Procedure code 70486 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8005. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 12052 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0134, which, per OPPS Addendum A, has a payment rate of $227.99. This amount multiplied by 60% yields an unadjusted labor-related amount of $136.79. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of $130.03. The non-labor related portion is 40% of the APC rate or $91.20. The sum of the labor and non-labor related amounts is $221.23. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $221.23 divided by the sum of all S and T APC payments of $676.79 gives an APC payment ratio for this line of 0.326881, multiplied by the sum of all S and T line charges of $7,421.75, yields a new charge amount of $2,426.03 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $221.23. This amount multiplied by 200% yields a MAR of $442.46.
- Procedure code 41899 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0250, which, per OPPS Addendum A, has a payment rate of $74.97. This amount multiplied by 60% yields an unadjusted labor-related amount of $44.98. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of $42.76. The non-labor related portion is 40% of the APC rate or $29.99. The sum of the labor and non-labor related amounts is $72.75. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $36.38 divided by the sum of all S and T APC payments of $676.79 gives an APC payment ratio for this line of 0.053754, multiplied by the sum of all S and T line charges of $7,421.75, yields a new charge amount of $398.95 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $36.38. This amount multiplied by 200% yields a MAR of $72.76.
- Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC ; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of $219.00. This amount multiplied by 60% yields an unadjusted labor-related amount of $131.40. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of $124.91. The non-labor related portion is 40% of the APC rate or $87.60. The sum of the labor and non-labor related amounts is $212.51. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The

outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $212.51. This amount multiplied by 200% yields a MAR of $425.02.

- Procedure codes 72125, 70450, and 70486 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8005, for computed tomography (CT) services without contrast; however, as no other CT services were provided, the criteria for composite payment are not met. This line is not assigned to a composite APC and may be paid separately. These services are classified under APC 8005, which, per OPPS Addendum A, has a payment rate of $431.98. This amount multiplied by 60% yields an unadjusted labor-related amount of $259.19. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of $246.39. The non-labor related portion is 40% of the APC rate or $172.79. The sum of the labor and non-labor related amounts is $419.18. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $419.18 divided by the sum of all S and T APC payments of $676.79 gives an APC payment ratio for this line of 0.619365, multiplied by the sum of all S and T line charges of $7,421.75, yields a new charge amount of $4,596.77 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $419.18. This amount multiplied by 200% yields a MAR of $838.36.

3. The total allowable reimbursement for the services in dispute is $1,865.62. This amount less the amount previously paid by the insurance carrier of $1,863.98 leaves an amount due to the requestor of $1.64. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1.64.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1.64, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 12, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee***

Dispute Resolution Findings and Decision together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.